RI MEDICAID

PROVIDER MANUAL

GENERAL GUIDELINES

Version 1.0

Revision History

Version	Date	Sections Revised	Reason for Revision
1.0	March, 2015	All sections	Newly Created

Table of Contents

INTRODUCTION 5
ENROLLMENT 5
Provider Enrollment 5
Trading Partner Agreement 5
Enrollment as a Trading Partner 6
Registration in the Healthcare Portal 6
Eligibility Verification and Claim Search Functions 6
ELIGIBILITY 6
Benefit Category 6
Prior Authorization 7
Third Party Liability (TPL) 7
CLAIMS PROCESSING 8
Covered and Non-covered Services 8
Electronic Claims Processing 8
Provider Electronic Solutions Software (PES) 9
Point of Service 9
Testing Claim Submission 9
Paper Claim Submission 9
Remittance Advice Document 9
Reprocessing of Claims 9
Medical Necessity 10
Denial of Medical Necessity 10
Appeal of Denial of Medical Necessity 10
Investigative/Experimental Medical Procedures 10
Demonstrated Reliable Evidence 11
Charging Medicaid Beneficiaries 11
Medicare/Medicaid Crossover 11
Other Insurance - Co-insurance, Deductible, and Co-payments 12
RIte Share 12

Timely Filing Requirements..... 13
Services and Utilization Reviews 14

INTRODUCTION

The Rhode Island Executive Office of Health and Human Services (EOHHS), in conjunction with HP Enterprise Services (HP), developed provider manuals for all Medicaid Providers. The purpose of this guide is to assist Medicaid providers with general Medicaid policy, coverage information and claim reimbursement applicable for all providers. Information pertaining to individual provider types is found in the more specific provider manuals. The HP Customer Service Help Desk is also available to answer questions not covered in these manuals.

HP ENTERPRISE SERVICES can be reached by calling:

- 1-401-784-8100 for local and long distance calls
- 1-800-964-6211 for in-state toll calls or border community calls

ENROLLMENT

For participation and recertification guidelines for specific provider programs and service types, please refer to the provider manual for that program or service type. The following enrollment guidelines are general in nature, and apply to all providers.

Provider Enrollment

HP Enterprise Services is the fiscal agent for EOHHS and the Medicaid Program, and as the fiscal agent is responsible for the enrollment, claims processing and reconciliation.

Providers must complete the enrollment process before claims are accepted. Information on enrollment is found on the Provider Enrollment tab of the EOHHS website. Select Provider Enrollment Application and Related forms to access the appropriate enrollment form and instructions for completion.

Trading Partner Agreement

A Trading Partner Agreement is required to access the secured portion of the EOHHS website. Providers must complete an Electronic Data Interchange (EDI) Trading Partner Agreement (TPA). Trading Partner enrollment allows access to the following:

- Electronic submission of claims
- Eligibility verification
- Claims status
- Access to Remittance Advice documents
- Third Party Liability and Prior Authorization information

Enrollment as a Trading Partner

New providers, and providers needing to re-enroll as a Trading Partner, must enroll as a Trading Partner in the RI Medicaid Healthcare Portal. Select the Trading Partner enrollment link from the homepage to complete the online Trading Partner enrollment application. After successful completion, a Trading Partner number is assigned. This number is then used to register in the Healthcare Portal. Instructions for enrollment and registration are found on the Healthcare Portal resource page

Registration in the Healthcare Portal

Once a Trading Partner number is obtained, that number must be used to register in the Healthcare Portal. Registration is required before any electronic services can be accessed.

From the homepage of the RI Medicaid Healthcare Portal, select the *Register Now* link and follow the online instructions. For additional help, a user guide and a quick reference troubleshooting guide are available on the Healthcare Portal resource page.

Eligibility Verification and Claim Search Functions

Once registered in the Healthcare Portal, Trading Partners must login to the RI Medicaid Healthcare Portal with their identification number and password. Once logged into the portal, the Trading Partner must select *My Profile*, and scroll down to the *Roles* section of the page and select the *Add Role* button. After entering the requested information, access to the eligibility verification and search claims functions will be enabled. Step by step instructions are available in the first section of the Quick Reference Guide.

ELIGIBILITY

Benefit Category

It is the responsibility of the provider to verify eligibility prior to providing service to a RI Medicaid beneficiary. Beneficiary eligibility can be verified on the RI Medicaid Healthcare Portal.

Trading Partners may verify the eligibility of beneficiaries, by selecting the *eligibility tab* on the orange tool bar in the RI Medicaid Healthcare Portal. The beneficiary's Medicaid ID number is required to perform an eligibility search. Eligibility should always be verified on the date of service before services are provided.

The RI Medicaid Program provides coverage for necessary medical services to beneficiaries who are Categorically Needy or Medically Needy. Both provide the same level of coverage, but the method of qualification is different.

Categorically Needy are those adults, families, pregnant women, and children who qualify based on income level, as well as those receiving cash assistance under the Aid

to Families with Dependent Children (AFDC) program, and the SSI program for the Aged, Blind or Disabled.

Medically Needy are those beneficiaries whose income or resources disqualify them for coverage, but qualify when a flexible test of income applies excess income to certain allowable medical expenses. This enables the individual to "spend down" to within a medically needy income limit (MNIL) established by the Medicaid agency.

Prior Authorization

Prior Authorization (PA) is required for specific procedures, services, and equipment as identified by the RI Medicaid Program. The request for Prior Authorization is initiated by the provider. Upon completion of the review, Prior Authorization status is available in the Healthcare Portal. Written notification of denials and incomplete requests are returned to the provider. The Medicaid program does not require providers to obtain prior authorization when other insurance is primary and there is a payment from that insurer. If the primary insurer does not make a payment and the services requires a prior authorization for RI Medicaid to make a payment, the provider must seek a prior authorization prior to submitting the claim for payment. Prior Authorization forms are found on the EOHHS website. Guidelines for specific services and procedures are found in the provider specific manuals. Prior authorization is not a guarantee of payment. There are exceptions to this rule for DME and Pharmacy providers. Please see the specific provider manual for guidelines.

Retroactive authorization is required in the following instances:

- Retroactive eligibility
- Primary payer benefits exhausted
- Primary payer recoupment

Third Party Liability (TPL)

Prior to billing RI Medicaid for services rendered to a beneficiary, providers are required to exhaust all other third party resources as the Medicaid program is the payer of last resort. It is the provider's responsibility to question the recipient as to the availability of Medicare and other insurance coverage prior to the provision of a service. Providers must bill third party payers and receive payment to the fullest extent possible before billing Medicaid. Private health care coverage and accident insurance, including coverage held by, or on behalf of, a Medicaid recipient is considered primary and must be billed according to the rules of the specific commercial plan.

To determine primary coverage, providers should obtain information from the beneficiary at the time service is provided. They should also verify third party coverage through the Healthcare Portal, using the eligibility verification function.

After exhausting all third party resources, the following information is required to appear on all claims billed to the Medicaid Program:

- Other insurance carrier name
- Policy number
- EOB (with explanation page if separate) from primary carrier if billed on paper
- Applicable TPL carrier code (found on EOHHS website)
- Payment amount from the other insurance, as well as copay, co-insurance, and deductible.

The Medicaid Program is not liable for payment of services that would have been reimbursable by the private payer if applicable rules of that private plan had been followed. The recipient must seek care from network providers and authorizations or referrals must be obtained as required. If the provider does not participate with the commercial carrier, the provider is expected to refer the recipient to a participating provider.

CLAIMS PROCESSING

For claims processing details for specific provider programs and service types, please refer to the provider manual for that program or service type. Claims may only be submitted for services after the delivery of the service.

Covered and Non-covered Services

Covered services are services that are listed in the Provider Manuals. Some services are subject to frequency limitations. If a service is needed beyond the frequency limitation, it does not mean that the service is “non-covered” and that the beneficiary may be charged for it.

Non-covered services are defined as those services that are not allowed per policy and are not due to frequency limitations.

Providers are required to consult the appropriate provider manual for covered services.

Electronic Claims Processing

Electronic submission of claims is the preferred method to expedite claims processing. Electronic claims offer:

- Cost savings
- Faster turnaround time
- Free Provider Electronic Solutions (PES) software for billing
- No original signature required
- Quicker corrections
- Quicker reimbursements

All Medicaid providers must utilize HIPAA compliant software to submit claims electronically. Providers in Rhode Island may use HP Enterprise Services' free software, Provider Electronic Solutions (PES), or software that has completed HIPAA compliance testing with HP Enterprise Services.

Provider Electronic Solutions Software (PES)

Free software is available for providers to submit claims electronically. Provider Electronic Solutions software (PES) is available to support your HIPAA compliant electronic billing needs and may be downloaded from the website. Electronic submission of claims ensures faster turnaround time, which increases payment to your office based on the validity of your submission.

Point of Service

Pharmacy claims are submitted POS, using NCPDP D.0 standards only. Pharmacy claims cannot be submitted using PES or paper.

Testing Claim Submission

Trading Partners who wish to test electronic claim submission with RI Medicaid should send a testing request to: riediservices@hp.com.

Paper Claim Submission

There may be instances when it is necessary to submit a claim on a paper claim form. For sample claim forms and instructions for completion, please visit the Forms and Applications page of the EOHHS website.

Remittance Advice Document

Remittance Advice (RA) documents are available to review the status of claims submitted to RI Medicaid. Remittance Advice documents are accessed electronically through the Healthcare Portal. Trading Partners can access the last four remittance advice documents. Once a new one is produced, the oldest one is no longer available. Trading Partners are encouraged to download or print these documents as soon as they become available to ensure access to this important information. The Payment and Processing Schedule for claims can be found on the Billing and Claims page of the EOHHS website

The first page of the RA contains important messages and updates for Trading Partners. For assistance in reading the document, visit Billing 101: Understanding Remittance Advice.

Reprocessing of Claims

At times, claims may need to be reprocessed. Adjustments may be requested on paid or partially paid claims. Recoupments are necessary when the full amount paid needs to be recouped. Recoupments are deducted from the next Medicaid payment to the provider. Refunds are made by sending checks payable to the State of Rhode Island. For detailed information, visit Billing 101: Adjustments, Recoupments and Refunds.

Medical Necessity

The RI Medicaid Program provides payment for covered services only when the services are determined to be medically necessary. The term "medical necessity" or "medically necessary service" means medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health related condition including such services necessary to prevent a decremental change in either medical or mental health status.

Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the beneficiary or service provider.

Denial of Medical Necessity

If the Medicaid Program is requested to pay as primary for a particular beneficiary who has other third party coverage (such as Medicare), and the third party denies payment based on medical necessity, then this determination is adopted by the Medicaid program and payment cannot be made.

Appeal of Denial of Medical Necessity

Determinations made by the Medicaid Program are subject to appeal by the recipient only. The route of appeal for recipients is through The Executive Office of Health and Human Services.

Investigative/Experimental Medical Procedures

Medical procedure of an investigative or experimental nature are not reimbursable by the Medicaid program.

A service furnished for research purposes in accordance with medical standards is considered experimental or investigational. A procedure is determined to be investigative or experimental according to the current judgment of the medical community as evidenced by medical research, studies, journals, or treatises.

The Medicaid Program determines whether a treatment, procedure, facility, drug or supply (each of which is hereafter called a "service") is experimental or investigational. The Medicaid program uses the following criteria to determine if a service is experimental or investigative.

1. The service is not yet approved by the appropriate governmental regulatory body or the service is approved for a purpose other than the purpose for which it is furnished; or

2. Demonstrated reliable evidence shows the service is (a) the subject of ongoing Phase I or II clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; (b) the subject of a written investigational or research protocol; or (c) the subject of a written informed

consent use by the treating facility when the written consent is obtained to assure that the patient acknowledges the non-standard nature of treatment.

Demonstrated Reliable Evidence

Demonstrated reliable evidence means: evidence including published reports and articles in authoritative, peer reviewed medical and scientific literature; and/or final approval of the service from the appropriate governmental regulatory body, demonstrating:

a) definite, measurable, positive effects of the service on health outcomes, with results supported by positive endorsements of national medical bodies or panels regarding their scientific efficacy and rationale; and proof that, over time, the beneficial effects of the service outweigh any harmful effects;

b) risk-benefit ratios as factorable as, if not better than, those of conventional treatments and significant advantages over such conventional treatments;

c) Improvement in health outcomes possible under the standard conditions of medical practice, outside the clinical investigatory settings;

d) The service is at least as beneficial in improving health outcomes as established technology or is usable in appropriate clinical contexts in which established technology is not employable.

Charging Medicaid Beneficiaries

Unless otherwise stipulated, the Medicaid Program reimbursement is considered payment in full. The provider is not permitted to seek further payment from the beneficiary in excess of the Medicaid Program rate. This includes the billing of a beneficiary resulting from a denied claim for any reason other than eligibility. In general, beneficiaries of RI Medicaid cannot be billed for any covered service or missed appointment. When it is stipulated that a beneficiary must “spend down” or contribute a portion of their personal income towards the cost of care, the amount of the beneficiary share will be indicated on the notice sent to the beneficiary.

Medicare/Medicaid Crossover

The Medicaid Program reimbursement for crossover claims is always capped by the established Medicaid Program allowed amount, regardless of coinsurance or deductible amounts. This includes Medicare replacement policies. Please see the Provider Manual for your provider type for specific calculation information.

Professional Crossovers
The Medicaid Program will pay the lesser of:

- The difference between the Medicaid Program allowed amount and the Medicare Payment (Medicaid Program allowed minus Medicare paid); or
- The Medicare coinsurance and deductible up to the Medicaid Program allowed amount

Institutional Claims
The Medicaid Program will pay:

- The provider's Ratio of Cost to Charges (RCC) percentage times the Medicare coinsurance and deductible.

Pharmacy Claims
The only claims that are covered are the Part D excluded drugs. Medicaid does not wrap co-payments or co-insurance for Medicare.

Other Insurance - Co-insurance, Deductible, and Co-payments

Medicaid Program beneficiaries who have other insurance may have a co-insurance, deductible, and/or co-payment liability amount that must be met. The other insurance carrier must be billed first, then the provider must submit the appropriate claim adjustment reason codes from the other carrier's EOB for electronic claims. Claims submitted on paper must include the other carrier's EOB. If the other insurance has paid for the service, the Medicaid Program will pay any co-insurance, deductible, and in some instances co-payment as long as the total amount paid by the other insurance does not exceed the Medicaid Program allowed amount(s) for the service(s). If the other insurer paid more than the Medicaid allowed amount, the claim will be paid at zero and is considered payment in full

RIte Share

RIte Share Premium Assistance Program subsidizes the costs of enrolling Medicaid eligible individuals and families in employer sponsored health insurance (ESI) plans that have been approved as meeting certain cost and coverage requirements.

RI Medicaid pays the ESI premium the policy holder must pay to the employer for his or her own individual coverage and for family/dependent coverage. Medicaid members enrolled in ESI are not obligated to pay any cost-sharing that is not otherwise applicable to Medicaid. The Medicaid agency pays for any ESI co-insurance and deductibles in such instances. Co-pays are not covered by the Medicaid agency, but RIte Share enrollees are not required to pay co-payments to Medicaid certified providers. The healthcare provider may not bill the RIte Share member for any cost-sharing required by the ESI, including co-payments. Services and benefits that are covered by Medicaid, but are not offered through the ESI plan, are made available

through the Medicaid program. Wrap-around services/coverage ensures that RIte Share enrollees receive health coverage comparable in scope, amount and duration to Medicaid members enrolled in RIte Care or Rhody Health Partners. Medicaid covers these services for Medicaid members participating in RIte Share enrollees when using Medicaid providers. The rules of the primary payer must be followed before Medicaid will process/reimburse claims for RIte Share members including using in-network providers.

Timely Filing Requirements

A claim for services provided to a Medicaid client, with no other health insurance, has to be received by the States' fiscal agent, HP Enterprise Services within 365 days of the date of service. If the claim is over a year old then a list of the criteria to bypass timely filing is as follows:

- Retroactive client eligibility (within the previous 90 days)
- Retroactive provider enrollment (within the previous 90 days)
- Previous denial from Medicaid (other than a timely filing denial) within the previous 90 days
- HP Enterprise Services processing error within the previous 90 days
- Recoupment of a claim within the previous 90 days. Please note that a recoupment of claims greater than 365 days are not allowed when a new claim will be submitted for increased reimbursement, unless there is a primary payer EOB dated within 90 days.
- Adjustments to a paid claim, over a year old, will be accepted up to 90 days from the remittance advice date that the original claim payment was posted. Adjustments for claims over one year old, cannot be adjusted to pay at a higher amount than originally paid.
- Prior Authorization or TPL updates within 90 days.

Claims with a date of service over one year that meet any of the above criteria must be submitted within ninety (90) days from the remittance advice date and/or PA or TPL update. Any claim appeal that does not meet these criteria will be denied for timely filing.

Claims with a date of service over one year with an involved third party payer (insurance) must be submitted within ninety (90) days of the payer's valid Explanation of Benefits (EOB) date. Denials for timely filing or failure to comply with the primary payer rules are not included in this exception.

Any claim with a service date over one year and an EOB date from another payer over 90 days will be denied for timely filing. Claims over 1 year old that meet the timely filing criteria must be sent to the Provider Representative for handling.

Services and Utilization Reviews

Medicaid, in the process of utilization review and/or in determining its responsibility for payment of services, may request the treating provider to submit appropriate diagnostic imaging and/or other clinical information, which justifies the treatment to the Medicaid Program. Payment may be denied if the requested diagnostic imaging and/or other clinical information are not submitted.

Medicaid reserves the right to refuse payment for treatment performed when the prognosis was unfavorable, the treatment impractical, or a lesser cost procedure would have achieved the same ultimate results.